



380 Empire Road Suite 200, Lafayette, CO 80026 Phone 303-926-7360 Fax 303-926-7359

Date _____

Dear _____, Welcome to Pain Partners, MD. We are proud to offer you an innovative approach to pain management using various non-surgical techniques.

Your appointment is scheduled for _____, _____ at _____ a.m. /p.m. Please arrive 10 minutes early for your appointment and bring your completed paperwork, insurance card(s) and driver's license.

The following policy applies to all providers of Pain Partners MD, LLC.

Our Policy of Payment

Insurance

- Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We are **not** contracted with **Medicaid**.
- We will file your insurance claim two times, if necessary. If it is denied, it will be your responsibility to follow up with your insurance company to resolve the claim.
- Not all services are a covered benefit in all insurance contracts. *All charges are your responsibility whether your insurance company pays or not.*
- **Co-pays must be paid at the time of your appointment.** *If you are unable to pay your co-pay you may reschedule your appointment.* Cancellations must be made 24 hours in advance or a **\$50.00 no show office visit fee & \$150.00 no show injection fee** will be charged.
- All patients are required to have a credit card on file. If balance is not paid within 10 days of statement, your credit card will be charged. For all balances over \$300 we will call you to give you the option of paying full balance with credit card on file or choosing a different mode of payment.
- Accounts become past due 30 days after your insurance pays. Statements are sent out weekly and the balance is due within 10 days of receipt. We reserve the right to send the account to a collection agency if the balance is not paid in full 45 days after your insurance pays its portion.
- In the event of your non-payment, you agree to pay, whether or not legal proceedings are instituted, a reasonable *collection agency fee* which shall be 35% of the principal balance for any debt incurred hereunder and to pay all reasonable costs of collection including but not limited to *court costs, attorney fees and interest* as a result of your default.

Cash Patients

- All cash patients must pay the cash fee at the time of service or be rescheduled for a later date.

Payment Options

We accept cash, money order, Visa or MasterCard for payment. *We do not accept personal checks.*

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

Patient Name (printed): _____

Patient or Representative Signature: _____ **Date:** _____

Relationship of Representative: _____